FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 8008518

Facility Name: Gottlieb Memorial Hospital

Address: 701 West North Aveneue (Number) Melrose Park (City) 60160 (Zip Code)

County: Cook

Telephone Number: (708)450-4949 **Fax #** (708)681-1688

IDPA ID Number:

Date of Initial License for Current Owners: 06/10/85

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Ellyn Chin **Telephone Number:** (708)450-4534

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Andrew Knauf

(Title) Vice President, Finance

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	34	Skilled (SNF)	34	12,444	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	34	TOTALS	34	12,444	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	102		7,608	7,710	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	102		7,608	7,710	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.96%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/20/85

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 34 and days of care provided 4,611

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	157,847	11,860	153,575	323,282		323,282		323,282			1
2	Food Purchase		5,869		5,869		5,869		5,869			2
3	Housekeeping	79,498	7,314	77,588	164,400		164,400		164,400			3
4	Laundry	11,850	21,169	64,023	97,042		97,042		97,042			4
5	Heat and Other Utilities			100,360	100,360		100,360		100,360			5
6	Maintenance	57,526	1,296	107,977	166,799		166,799		166,799			6
7	Other (specify):* Cafeteria	3,956	273	27,202	31,431	(31,431)						7
8	**TOTAL General Services**	310,677	47,781	530,725	889,183	(31,431)	857,752		857,752			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,236,177	57,245	136,157	1,429,579		1,429,579		1,429,579			10
10a	Therapy											10a
11	Activities											11
12	Social Services	46,730	294	33,793	80,817		80,817		80,817			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* CPD/Pharmacy	2,985	5,357	3,388	11,730		11,730		11,730			15
16	**TOTAL Health Care and Programs**	1,285,892	62,896	173,338	1,522,126		1,522,126		1,522,126			16
	C. General Administration											
17	Administrative	57,674	1,482	53,773	112,929		112,929		112,929			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses											21
22	Employee Benefits & Payroll Taxes			229,908	229,908	31,431	261,339		261,339			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			24,086	24,086		24,086		24,086			26
27	Other (specify):*											27
28	**TOTAL General Administration**	57,674	1,482	307,767	366,923	31,431	398,354		398,354			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,654,243	112,159	1,011,830	2,778,232		2,778,232		2,778,232			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Gottlieb Memorial Hospital #8008518 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			226,559	226,559		226,559		226,559			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			30,504	30,504		30,504		30,504			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			257,063	257,063		257,063		257,063			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,109,521	1,109,521		1,109,521		1,109,521			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			1,109,521	1,109,521		1,109,521		1,109,521			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,654,243	112,159	2,378,414	4,144,816		4,144,816		4,144,816			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Gottlieb Memorial Hospital

ID# 8008518

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	0		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Gottlieb Memorial Hospital **#** 8008518 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	0	0	0	0	0	0	0	0	0	0	0	45

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Meals Served	127,143		$ 1,654,312	$ 807,740	24,846	$ 323,282	1
2	2	Food Purchase	Meals Served	127,143		30,031	0	24,846	5,869	2
3	3	Housekeeping	Time Spent	26,693		1,959,082	947,338	2,240	164,401	3
4	4	Laundry	Pounds of Laundry	36,623		660,591	80,666	5,380	97,042	4
5	5	Heat/Utilities	Square Feet	194,315		1,595,863	0	12,220	100,360	5
6	6	Plant	Square Feet	194,315		1,164,392	388,518	12,220	73,226	6
7	7	Cafeteria	FTEs Served	64,566		606,875	76,385	3,344	31,431	7
8	10	Nursing	Direct RN Hours	41,960		2,156,505	1,328,271	3,344	171,863	8
9	10	Medical Records	Time Spent	5,762		1,508,755	912,949	296	77,506	9
10	12	Social Services	Time Spent	8,708		393,160	227,334	1,790	80,817	10
11	15	Central Supply	Costed Req	1,358,678		944,167	217,662	15,514	10,781	11
12	15	Pharmacy	Costed Req	2,238,894		2,197,144	1,157,364	967	949	12
13	17	Administration	Revenue	316,155,226		11,595,629	5,921,981	3,079,037	112,930	13
14	22	Employee Benefits	Gross Salaries	41,741,428		8,678,066	0	1,105,855	229,908	14
15	26	Property Insurance	Square Feet	194,315		99,490	0	12,220	6,257	15
16	6	Maintenance	Time Spent	56,430		1,920,130	679,073	2,750	93,574	16
17	26	Malpractice Insurance	Revenue	316,155,226		1,830,690	0	3,079,037	17,829	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 38,994,882	$ 12,745,281		$ 1,598,025	25

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	IHFA		X	Refinance & Equipment	Interest	1990	$ 27,209,221	$ 26,018,801	11/15/25	Floating	$ 10,562	1
2	IHFA		X	Refinance & Equipment	Interest	1994	12,477,021	12,300,000	11/15/24	Floating	4,973	2
3	IHFA		X	Refinance & Equipment	Interest	1999	28,900,000	28,668,350		Floating	11,606	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 68,586,242	$ 66,987,151			$ 27,141	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 68,586,242	$ 66,987,151			$ 27,141	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Gottlieb Memorial Hospital **#** 8008518 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995		8
1996		9
1997		10
1998		11
1999		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,220 B. General Construction Type: Exterior Concrete Frame Reinforced Concrete Number of Stories

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Hospital & Parking	1,458,000	1961	$ 61,937	1
2					2
3	TOTALS	1,458,000		$ 61,937	3

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1961	1961	$ 1,789,885	$ 35,798	50	$ 35,798	$	$ 1,414,013	4
5			1982	1982	1,135,357	39,150	29	39,150		724,277	5
6					(2,741,244)	(70,234)		(70,234)		(2,003,792)	6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1961	927,147		25			927,147	9
10	Building Improvements			1962	5,314	108	49	108		4,109	10
11	Building Improvements			1963	57,578	1,152	47-50	1,152		43,195	11
12	Building Improvements			1964	154	3	46	3		114	12
13	Building Improvements			1965	839,469	9,188	25-50	9,188		706,243	13
14	Building Improvements			1966	18,069	181	20-45	181		16,070	14
15	Building Improvements			1967	99,677	1,123	25-44	1,123		87,893	15
16	Building Improvements			1969	243,126	3,854	10-42	3,854		203,010	16
17	Building Improvements			1970	10,866		15-25			10,866	17
18	Building Improvements			1971	410,569	4,156	20-40	4,156		367,210	18
19	Building Improvements			1972	63,023	286	10-39	286		60,139	19
20	Building Improvements			1973	36,443		15-20			36,443	20
21	Building Improvements			1974	70,028	1,796	15-37	1,796		51,116	21
22	Building Improvements			1975	2,422		10			2,422	22
23	Building Improvements			1976	3,446,023	58,778	5-36	58,778		2,933,066	23
24	Building Improvements			1977	7,474,834	118,567	5-35	118,567		6,324,997	24
25	Building Improvements			1978	172,682	2,174	5-35	2,174		156,488	25
26	Building Improvements			1979	159,159	1,234	5-34	1,234		145,971	26
27	Building Improvements			1980	729,897	15,350	8-31	15,350		572,623	27
28	Building Improvements			1981	1,633,608	58,931	10-11	58,931		1,362,611	28
29	Building Improvements			1982	3,024,034	112,224	6-20	112,224		2,682,541	29
30	Building Improvements			1983	3,028,019	111,444	5-28	111,444		2,051,492	30
31	Building Improvements			1984	245,719	9,407	5-20	9,407		210,800	31
32	Building Improvements			1985	7,212,994	242,733	5-40	242,733		4,800,800	32
33	Building Improvements			1986	2,251,370	100,416	5-20	100,416		1,710,713	33
34	Less Improv Allocated to Other Areas				(30,139,220)	(799,445)		(799,445)		##########	34
35											35
36	TOTAL (lines 4 thru 35)				$ 2,207,002	$ 58,375		$ 58,375	$	$ 1,736,441	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1987	1,228,658	47,304	5-40	47,304		888,441	9
10	Building Improvements			1988	1,055,957	45,163	10-20	45,163		709,533	10
11	Building Improvements			1989	5,888,073	282,247	5-25	282,247		3,463,141	11
12	Building Improvements			1990	5,443,853	273,902	5-20	273,902		2,770,036	12
13	Building Improvements			1991	2,702,153	135,494	10-20	135,494		1,243,266	13
14	Building Improvements			1992	2,395,627	119,134	2-20	119,134		1,020,350	14
15	Building Improvements			1993	1,601,818	79,039	2-20	79,039		600,525	15
16	Building Improvements			1994	2,930,128	147,496	20	147,496		967,929	16
17	Building Improvements			1995	4,798,468	236,879	20	236,879		1,312,581	17
18	Co Generator Construction			1996	1,524,624	76,231	20	76,231		365,331	18
19	Emergency Water Main			1996	28,313	1,416	20	1,416		6,094	19
20	Absorption Chiller Construction			1996	558,317	27,916	20	27,916		131,040	20
21	Architecture Fees			1996	591,268	29,563	20	29,563		132,478	21
22	Hospital Signage			1996	9,074	454	20	454		2,136	22
23	Install Backflow Preventers			1996	23,735	1,187	20	1,187		5,562	23
24	Plumbing			1996	1,133	57	20	57		274	24
25	Remove Fiber Optics			1996	6,184	309	20	309		1,469	25
26	Emergency Elevator Power			1996	7,800	390	20	390		1,820	26
27	POB Improvements			1996	475,382	23,769	20	23,769		110,218	27
28	Heating Work			1996	1,220	61	20	61		249	28
29	Construction Hospital Entrance			1996	118,241	5,912	20	5,912		24,393	29
30	Lightening Protection			1996	9,912	496	20	496		2,478	30
31	Remodel Home Health,Radiology,Same Day Surgery			1996	72,807	3,641	20	3,641		16,458	31
32	Miscellaneous Improvements			1996	52,594	2,630	20	2,630		15,062	32
33	Warehouse			1996	25	1	20	1		6	33
34	Less Improv Allocated to Other Areas				(29,542,419)	########		(1,443,782)		##########	34
35											35
36	TOTAL (lines 4 thru 35)				$ 1,982,945	$ 96,909		$ 96,909	$	$ 867,446	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Remodel ICU,West Wing,Medical Staff Office			1996	33,732	1,687	20	1,687		7,355	9
10	Slope Sink Mechanical			1996	2,168	108	20	108		524	10
11	Remodel South Wing,OR,Audiology			1996	211,819	10,591	20	10,591		51,428	11
12	Carpeting			1996	2,073	104	20	104		502	12
13	Cath Lab/Angio Addition			1996	600,588	29,839	20	29,839		127,223	13
14	Cath Lab/Angio Addition			1997	29,968	1,498	20	1,498		5,803	14
15	Miscellaneous Improvements			1997	69,113	3,456	20	3,456		11,114	15
16	Architectural Fees			1997	241,107	12,055	20	12,055		42,444	16
17	Co Generator Construction			1997	26,349	1,317	20	1,317		4,689	17
18	Remodel Data Proc,OR,2 West,Audiology			1997	74,795	3,740	20	3,740		14,051	18
19	POB Improvements			1997	39,906	1,995	20	1,995		7,329	19
20	Hospital Entrance Construction			1997	2,102,804	105,140	20	105,140		383,910	20
21	Daycare Construction			1997	862,706	43,283	20	43,283		146,810	21
22	Remodel TCT Suite,Radiology,GI Lab,Labor Room			1997	70,531	3,527	20	3,527		11,062	22
23	Hospital Signage			1997	2,703	135	20	135		437	23
24	Retention Pond Installation			1997	51,168	2,558	20	2,558		8,298	24
25	POB Addition			1997	245,437	12,272	20	12,272		42,738	25
26	Locks			1997	926	46	20	46		174	26
27	Emergency Water Main			1997	2,900	145	20	145		532	27
28	Roof Repairs			1997	698	35	20	35		128	28
29	Remodel Same Day Surg, 3,4,5 South, Emergency Rm			1997	30,402	1,520	20	1,520		5,113	29
30	Remodel Main Lobby			1997	293	15	20	15		48	30
31	Remodel Labor Room,Radiology,Emergency Room			1998	382,897	19,145	20	19,145		54,865	31
32	Daycare Construction			1998	878,415	46,007	20	46,007		127,924	32
33	Remodel Main Lobby			1998	940	47	20	47		141	33
34	Less Improv Allocated to Other Areas				(5,589,275)	(281,378)		(281,378)		(988,305)	34
35											35
36	TOTAL (lines 4 thru 35)				$ 375,163	$ 18,887		$ 18,887	$	$ 66,337	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Miscellaneous Improvements			1998	45,301	2,265	20	2,265		5,964	9
10	POB Improvments			1998	708,705	35,435	20	35,435		86,612	10
11	Co Generator Construction			1998	5,910	296	20	296		887	11
12	Hospital Signage			1998	49,712	2,486	20	2,486		5,328	12
13	POB Addition			1998	3,375,598	168,780	20	168,780		445,535	13
14	Hospital Entrance Construction			1998	38,075	1,904	20	1,904		5,153	14
15	Retention Pond			1998	8,952	448	20	448		1,302	15
16	Architecture Fees			1998	1,224,933	61,247	20	61,247		152,411	16
17	Remodel West Wing,OR,Phys Therapy,CT Suite			1998	659,300	32,965	20	32,965		83,426	17
18	HVAC Improvements			1998	370,685	18,534	20	18,534		47,759	18
19	Cath Lab/Angio Addition			1998	660	33	20	33		91	19
20	Telephone System Improvements			1998	41,722	2,086	20	2,086		5,563	20
21	Remodel Data Processing			1998	6,781	339	20	339		848	21
22	Remodel Eye Center,ICU			1998	28,241	1,412	20	1,412		3,002	22
23	Architecture Fees			1999	230,457	11,523	20	11,523		21,815	23
24	Back to Work Center			1999	802	40	20	40		80	24
25	Hospital Signage			1999	8,479	424	20	424		693	25
26	POB Improvments			1999	757,033	37,852	20	37,852		61,317	26
27	Construction Hospital Entrance			1999	5,825	291	20	291		478	27
28	Remodel Phys Ther,Pharmacy,Home Hth,Lab			1999	475,285	23,764	20	23,764		42,267	28
29	Remodel TCT Suite,Radiology,6 Sth,West Wing			1999	661,416	23,447	20	23,447		36,462	29
30	Remodel Emergency Room			1999	195,419	9,771	20	9,771		12,453	30
31	Integrated Medicine			1999	34,842	1,742	20	1,742		2,519	31
32	Co Generator Construction			1999	640	32	20	32		37	32
33	Miscellaneous Improvements			1999	2,397	120	20	120		178	33
34	Less Improv Allocated to Other Areas				(8,375,022)	(409,734)		(409,734)		(957,885)	34
35											35
36	TOTAL (lines 4 thru 35)				$ 562,148	$ 27,502		$ 27,502	$	$ 64,295	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	HVAC			1999	4,460	223	20	223		397	9
10	Daycare Construction			1999	24,254	1,213	20	1,213		1,865	10
11	Fire Alarm System			1999	97,371	4,869	20	4,869		7,223	11
12	POB Addition			1999	1,277,351	63,868	20	63,868		102,034	12
13	Warehouse			1999	7,126	356	20	356		576	13
14	Master Plan Fees			1999	355,946	8,892	20	8,892		15,337	14
15	Master Plan Fees			2000	5,028,870	34,194	20	34,194		34,194	15
16	Miscellaneous Improvements			2000	25,154	270	20	270		270	16
17	Fire Alarm System			2000	12,000	517	20	517		517	17
18	Remodel Labor Room,Radiology,Surgery			2000	15,999	433	20	433		433	18
19	Remodel ER,6 South,Phys Therapy,West Wing			2000	567,340	15,642	20	15,642		15,642	19
20	Warehouse			2000	9,357	390	20	390		390	20
21	POB Improvements			2000	328,012	11,056	20	11,056		11,056	21
22	Medical Staff Office			2000	3,118	26	20	26		26	22
23	Remodel South Wing			2000	52,177	251	20	251		251	23
24	POB Addition			2000	89,206	3,856	20	3,856		3,856	24
25	Remodel MRI			2000	840	28	20	28		28	25
26	Architecture Fees			2000	77,316	850	20	850		850	26
27	Land Improvements (Total Hospital)				4,405,374	137,544	5-25	137,544		3,674,627	27
28											28
29											29
30											30
31											31
32											32
33	Less Improv Allocated to Other Areas				(11,602,489)	(266,584)		(266,584)		(3,626,176)	33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 778,782	$ 17,894		$ 17,894	$	$ 243,396	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 47,942	$ 6,591	$ 6,591	$	5-11	$ 24,863	37
38	Current Year Purchases	3,228	401	401		3-5	401	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 51,170	$ 6,992	$ 6,992	$		$ 25,264	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 6,019,147	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 226,559	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 226,559	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 3,003,179	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 7,097,486	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,592,819)	21,236,079		3
4	Supply Inventory (priced at cost)	1,923,947		4
5	Short-Term Investments	20,026,362		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	782,381		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due From Affiliates	14,629,214		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 65,695,469	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	86,655,301		12
13	Land	4,293,071		13
14	Buildings, at Historical Cost	93,895,709		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	42,997,118		16
17	Accumulated Depreciation (book methods)	(81,314,795)		17
18	Deferred Charges	4,264,367		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Inv in PHO,Self Ins F	2,360,636		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 153,151,407	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 218,846,876	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,253,571	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	4,432,610		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Exp/Bond Payable	2,220,530		36
37	Third Party Settlement	7,359,107		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 17,265,818	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	65,680,061		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Reserve for Self Insurance	3,088,100		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 68,768,161	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 86,033,979	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 132,812,897	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 218,846,876	$	48

***(See instructions.)**

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):	118,175,204	2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 118,175,204	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	14,637,693	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 14,637,693	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 132,812,897	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 316,155,226	1
2	Discounts and Allowances for all Levels	(220,356,237)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 95,798,989	3
	B. Ancillary Revenue		
4	Day Care	567,951	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 567,951	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	351,336	14
15	Telephone, Television and Radio	1,959	15
16	Rental of Facility Space	504,856	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,078,904	19
20	Radiology and X-Ray	15,597	20
21	Other Medical Services	37,957	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,990,609	23
	D. Non-Operating Revenue		
24	Contributions	371,581	24
25	Interest and Other Investment Income***	6,021,136	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,392,717	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Non Operating Revenue	961	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 961	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 104,751,227	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	90,113,534	31
32	Health Care		32
33	General Administration		33
	B. Capital Expense		
34	Ownership		34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 90,113,534	40
41	**Income before Income Taxes (line 30 minus line 40)****	14,637,693	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 14,637,693	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,944	2,080	$ 62,780	$ 30.18	1
2	Assistant Director of Nursing					2
3	Registered Nurses	17,501	19,981	508,137	25.43	3
4	Licensed Practical Nurses	8,724	9,815	153,647	15.65	4
5	Nurse Aides & Orderlies	21,357	23,919	250,176	10.46	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,795	1,927	23,464	12.18	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	1,969	2,204	39,125	17.75	22
23	Office Manager					23
24	Clerical	4,028	4,721	54,385	11.52	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	57,318	64,647	$ 1,091,714 *	$ 16.89	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	202	$ 14,140		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	202	$ 14,140		53

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed ____)	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 0 Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 0
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 31,431 Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: Ernst and Young The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.